Thomas Yoon Dental

Patient Information Update

Today's date: _____

Patient Name: _____
Last First MI (Preferred Name)

Date of Birth: _____/_____/_____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Address: _____
Street

_____
City State Zip Code

E-mail Address: _____

Contact preference: ☐ Phone Call ☐ Email ☐ Both

Insurance Information Update

☐ **Check here if this information has not been changed**

☐ Self Pay

Primary Dental Insurance

Insurance company and Plan Name_____

Insurance ID #: _____ Group # _____

Name of Subscriber: _____ Subscriber's Birth Date: _____

Insured's Employer Name: _____

Insurance Company Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Dental Insurance

Insurance company and Plan Name_____

Insurance ID #: _____ Group # _____

Name of Subscriber: _____ Subscriber's Birth Date: _____

Insured's Employer Name: _____

Insurance Company Address: _____
Street City State Zip Code

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

(Continue to page 2→)

Health Information Update

☐ **Check here if this information has not been changed**

Have you ever had any of the following?

	yes	no		yes	no		yes	no		yes	no
AIDS/HIV	O	O	Excessive Bleeding	O	O	Liver Disease	O	O	Stroke	O	O
Allergies	O	O	Fainting	O	O	Mental Disorders	O	O	Tuberculosis	O	O
Anemia	O	O	Glaucoma	O	O	Nervous Disorders	O	O	Tumors	O	O
Anxiety	O	O	Growths	O	O	Pacemaker	O	O	Ulcers	O	O
Arthritis	O	O	Hay Fever	O	O	Currently pregnant	O	O	Venereal Disease	O	O
Artificial Joints	O	O	Head Injuries	O	O	Due date: _____			Codeine Allergy	O	O
Asthma	O	O	Heart Disease	O	O	Radiation Treatment	O	O	Penicillin Allergy	O	O
Blood Disease	O	O	Heart Murmur	O	O	Respiratory Problems	O	O	Osteoporosis	O	O
Cancer	O	O	Hepatitis	O	O	Rheumatic Fever	O	O	OTHER:	O	O
Diabetes	O	O	High Blood Pressure	O	O	Rheumatism	O	O	_____		
Dizziness	O	O	Jaundice	O	O	Sinus Problems	O	O	_____		
Epilepsy	O	O	Kidney Disease	O	O	Stomach Problems	O	O			
Difficulty swallowing	O	O	Smoking	O	O	Interested in whitening	O	O	Popping Jaw	O	O
Difficulty chewing	O	O	____/day, How long ____yr			Interested in nice smile	O	O	Headaches	O	O
Bad Breath	O	O	Sensitive teeth	O	O	Interested in nightguard	O	O	Neck/upper back pain	O	O
Grinding	O	O	Bleeding gums	O	O	History of Braces	O	O	Jaw pain	O	O
Currently own nightguard?	O	O	Clenching	O	O	TMJ problem	O	O	Facial pain	O	O

- Do you have or have you ever had any problem, disease or disease not listed above ☐ Yes ☐ No

If yes, please explain: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

- Are you taking any medications daily including Aspirins ☐ Yes ☐ No

If yes, the name of medicines: _____

- Are you aware of having an allergic reaction to any medications ☐ Yes ☐ No

If yes, please list: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of Provider